



MISSOURI DEPARTMENT OF TRANSPORTATION
MOTOR CARRIER SERVICES

**STATEMENT OF TREATING PHYSICIAN, FOR SKILL PERFORMANCE
EVALUATION (SPE) CERTIFICATE TO OPERATE INTRASTATE COMMERCIAL
MOTOR VEHICLES**

SPEC-B FORM

(Statement of Treating Physician,
Required by RSMo 622.555)

MAIL COMPLETED FORM TO:	ATTN: MEDICAL EXEMPTION PROGRAM MOTOR CARRIER SERVICES P.O. BOX 893 JEFFERSON CITY, MO 65102-0893	IF ASSISTANCE NEEDED, CALL: 573-522-9001 OR Toll Free at 1-866-831-6277 FAX 573-522-4260
--------------------------------	--	--

SECTION 1. IDENTIFICATION OF DRIVER-APPLICANT (To be completed by driver applicant).

DRIVER-APPLICANT'S FULL NAME				
RESIDENCE ADDRESS			GENDER (Please check one box) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY	STATE	ZIP	DATE OF BIRTH	
(AREA CODE) HOME TELEPHONE # ()	(AREA CODE) WORK PHONE # (IF ANY) ()		SOCIAL SECURITY #	
DRIVER'S LICENSE #	STATE WHICH ISSUED	DATE ISSUED	EXPIRATION DATE	

SECTION 2. IDENTIFICATION OF TREATING PHYSICIAN

TREATING PHYSICIAN'S BUSINESS NAME			BOARD CERTIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	
TREATING PHYSICIAN'S FULL NAME			BOARD ELIGIBLE <input type="checkbox"/> YES <input type="checkbox"/> NO	
BUSINESS ADDRESS				
CITY		STATE	ZIP	
(AREA CODE) OFFICE TELEPHONE # ()	(AREA CODE) OFFICE FAX # ()		PROFESSIONAL CERTIFICATION #	
NAME OF CERTIFYING ORGANIZATION			PROFESSIONAL LICENSE #	
ADDRESS OF CERTIFYING ORGANIZATION				
CITY		STATE	ZIP	

SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN

<input type="checkbox"/> A	PLEASE GIVE A BRIEF DESCRIPTION OF THE APPLICANT'S MEDICAL CONDITION FOR WHICH A SKILL PERFORMANCE EVALUATION CERTIFICATE IS NECESSARY. ←CHECK BOX TO CONFIRM COMPLETION.
<input type="checkbox"/> B	IS THE PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH ACTUAL TREATMENT? ←CHECK BOX TO CONFIRM COMPLETION.
<input type="checkbox"/> YES - HOW LONG?	<input type="checkbox"/> NO - EXPLAIN:

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.

SECTION 3. TO BE COMPLETED BY TREATING PHYSICIAN (Continued)

C <input type="checkbox"/>	IS THE TREATING PHYSICIAN FAMILIAR WITH THE APPLICANT'S MEDICAL HISTORY THROUGH CONSULTATION WITH ANOTHER PHYSICIAN WHO HAS TREATED THE APPLICANT?
----------------------------	--

<input type="checkbox"/> YES	PHYSICIAN'S NAME	BUSINESS ADDRESS
------------------------------	------------------	------------------

CITY	STATE	ZIP	(AREA CODE) BUSINESS TELEPHONE # ()
------	-------	-----	--

<input type="checkbox"/> NO - EXPLAIN:
--

D <input type="checkbox"/>	DOES THE APPLICANT HAVE THE ABILITY AND WILLINGNESS TO FOLLOW ANY COURSE OF TREATMENT PRESCRIBED, INCLUDING THE ABILITY TO SELF-MONITOR OR MANAGE THE MEDICAL CONDITION?
----------------------------	--

<input type="checkbox"/> YES	<input type="checkbox"/> NO - EXPLAIN:
------------------------------	--

E <input type="checkbox"/>	IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION ADVERSELY AFFECT HIS/HER ABILITY TO OPERATE A COMMERCIAL MOTOR VEHICLE SAFELY?
----------------------------	---

<input type="checkbox"/> YES	<input type="checkbox"/> NO - EXPLAIN:
------------------------------	--

F <input type="checkbox"/>	IN YOUR PROFESSIONAL OPINION, WILL THE APPLICANT'S CONDITION LIKELY REMAIN STABLE OVER THE LIFETIME OF THE DRIVER-APPLICANT?
----------------------------	--

<input type="checkbox"/> YES	<input type="checkbox"/> NO - EXPLAIN:
------------------------------	--

SECTION 4. TREATING PHYSICIANS CERTIFICATION AND VERIFICATION

I FURTHER DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF MISSOURI AND THE UNITED STATES OF AMERICA THAT ALL THE INFORMATION STATED IN THIS APPLICATION, AND ALL ATTACHED INFORMATION ARE TRUE AND CORRECT.

TREATING PHYSICIAN'S NAME (Printed)	DATE SIGNED:
-------------------------------------	--------------

TREATING PHYSICIAN'S SIGNATURE

NOTE: IF MORE SPACE IS NEEDED FOR YOUR RESPONSE(S) THAN THE FORM PROVIDES, PLEASE ATTACH ADDITIONAL SHEETS.